Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1 DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name

OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box

Box Number 44

MFDR Tracking Number

M4-11-3751-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the preauthorization letter, EOBs, claims, and documentation. The patient was referred for the Chronic Pain Management program. The services were provided and the claims were denied per EOB precertification/authorization/notification absent. CPT code 97799 CPCA was preauthorized, IRO Case #32943. Please refer to the attached IRO decision for further reference. "

Amount in Dispute: $9,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 8, 2011 March 9, 2011 March 10, 2011 March 11, 2011 March 14, 2011 March 15, 2011 March 16, 2011 March 17, 2011 March 18, 2011	Chronic Pain Management Program – CPT Code 97799-CPCA (8 hours per day)	$9,000.00	$9,000.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.308 sets out the procedures for resolving a medical necessity dispute
3. 28 Texas Administrative Code §134.204, Medical Fee Guideline for Workers' Compensation Specific Services. *March 1, 2008, 33 TexReg 626*, sets the reimbursement guidelines for the disputed service.
4. 28 Texas Administrative Code §134.600, requires preauthorized for specific treatments and services The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 27, 2011
   - 197-Precertification/authorization/notification absent.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

   Explanation of benefits dated May 5, 2011
   - 197-Precertification/authorization/notification absent.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

   Explanation of benefits dated May 8, 2011
   - 197-Precertification/authorization/notification absent.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

   Explanation of benefits dated May 22, 2011
   - 197-Precertification/authorization/notification absent.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

   Explanation of benefits dated June 5, 2011
   - 197-Precertification/authorization/notification absent.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

Issues

1. Did the requestor support position that preauthorization was obtained for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the disputed services based upon "197-Precertification/ authorization/notification absent."

   The requestor states in the position summary that "CPT code 97799 CPCA was preauthorized, IRO Case #32943. Please refer to the attached IRO decision for further reference."

   Per 28 Texas Administrative Code §134.600(o)(3), "If the initial response is a denial of preauthorization, the requestor or employee may request reconsideration. If the initial response is a denial of concurrent review, the requestor may request reconsideration. (3) The requestor or employee may appeal the denial of a reconsideration request regarding medical necessity by filing a dispute in accordance with Labor Code §413.031 and related Division rules."

   Per 28 Texas Administrative Code §133.308(g)(2)(A), "Requestors. The following parties may be requestors in medical necessity disputes: (2) In non-network disputes: (A) providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, as described in Labor Code §413.0111, for preauthorization, concurrent, and retrospective medical necessity dispute resolution."

   Per 28 Texas Administrative Code §133.308(p)(1)(E), "IRO Decision. The decision shall be mailed or otherwise transmitted to the parties and to representatives of record for the parties and transmitted in the form and manner prescribed by the Department within the time frames specified in this section. (1) The IRO decision must include: (E) a statement that clearly states whether or not medical necessity exists for each of the health care services in dispute."

   On March 3, 2011, an Independent Review Organization decision was issued that overturned the insurance carrier's denial of the medical necessity of the additional ten (10) sessions of chronic pain management.
2. Per 28 Texas Administrative Code §133.308(v) "Medical Fee Dispute Request. If the requestor has an unresolved fee dispute related to health care that was found medically necessary, after the final decision of the

medical necessity dispute, the requestor may file a medical fee dispute in accordance with §133.305 and §133.307 of this subchapter (relating to MDR of Fee Disputes)."

The Division finds that the requestor is seeking medical fee dispute resolution for the chronic pain management program that was found to be medically necessary by the IRO decision of March 3, 2011. The disputed services will be reviewed per applicable rules and fee guidelines.

28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP-CA for eight (8) hours on the nine (9) disputed dates of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour times eight (8) hours = $1000.00 per day. $1000.00 times the nine disputed dates is $9,000.00. The carrier paid $0.00. Therefore, the difference between the MAR and amount paid is $9,000.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $9,000.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/06/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.